Foster Family Home - Corrective Action Report

Provider ID: 1	-562571		•			**
Home Name: Y	'olanda De	Vera, CNA	Review ID:	1-562571-4		
1586 Moani Street			Reviewer:	Sue Lo		•
Honolulu	Н	II 96819	Begin Date:	2/24/2017	End Date:	3/6/2017
Foster Family H	ome	Required Certific	ate	[17	-1454-6]	, , , , , , , , , , , , , , , , , , ,
6.(d)(1)	Comply wi	ith all applicable requ	irements in this ch	apter; and		
Comment:						
		n 2/24/2017 for a 3- home visit with cor				2-bed recertification. Corrective
6 (d)(1) see appli	cable secti	ions of this review.				
Foster Family H	ome	Personnel and S	taffing	[17	-1454-41]	
41.(b)(7)	Have a cu	rrent tuberculosis cle	arance that meets	department of he	aith guidelines	s; and
41.(f)				dult household m	embers who a	re not substitute caregivers with
Comment:	evidence t	hat they have curren	IC			
	16/16 for C	G#2; due on/befor				CG#1; due on/before 10/3/2016 and due on/before 10/9/16 -
Foster Family H	ome	Quality Assuran	c o '	[17	-1454-48.1]	
48.1.(b)	Adverse e	vents shall be report	ed			
Comment:						••••••
48.1.(b) Docume	ntation for	medication error n	ot present in the I	nome for Client	#1.	
				,		
	Complia	nce Manager	1414 · · · · · · · · · · · · · · · · · ·		Date	<u> </u>
		_				_
	Primary	Care Giver	·····		Date	Ans/17
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Written plan of Correction

41.(b)(7): CG #1, CG #2, CG #3, HHM #3

will not lapse in TB Clearance in the future because i will do TB Screening before it expires
by using a calendar to remind me before the due date to ensure it will not happen again in the
future.

41.1(b)

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- Adverse report completed, 2/24/17, Faxed to Case Manager, RN.
- -To prevent tis from happening in the future, I will utilize the Five (5) Rights of Administering Medication for client #1, and for all clients in the future.

February 27,2017

Yolarida De Vera 1586 Moani Street Henolulu HI 96819